

<i>SERFF Tracking Number:</i>	<i>AGDE-125989880</i>	<i>State:</i>	<i>Arkansas</i>
<i>Filing Company:</i>	<i>National Union Fire Insurance Company of Pittsburgh, PA</i>	<i>State Tracking Number:</i>	<i>41907</i>
<i>Company Tracking Number:</i>	<i>S30642DBG</i>		
<i>TOI:</i>	<i>H04 Health - Blanket Accident/Sickness</i>	<i>Sub-TOI:</i>	<i>H04.000 Health - Blanket Accident/Sickness</i>
<i>Product Name:</i>	<i>Speciality Markets</i>		
<i>Project Name/Number:</i>	<i>Admendment Endorsement for Organ Donor Transplant/S30642DBG</i>		

## Filing at a Glance

Company: National Union Fire Insurance Company of Pittsburgh, PA

Product Name: Speciality Markets      SERFF Tr Num: AGDE-125989880      State: Arkansas

TOI: H04 Health - Blanket Accident/Sickness      SERFF Status: Closed-Approved-  
Closed      State Tr Num: 41907

Sub-TOI: H04.000 Health - Blanket  
Accident/Sickness      Co Tr Num: S30642DBG      State Status: Approved-Closed

Filing Type: Form      Reviewer(s): Rosalind Minor

Authors: Wanda Floyd, Jane Ford,      Disposition Date: 01/28/2009

Penny Berry

Date Submitted: 01/23/2009      Disposition Status: Approved-  
Closed

Implementation Date Requested: On Approval

Implementation Date:

State Filing Description:

## General Information

Project Name: Admendment Endorsement for Organ Donor Transplant      Status of Filing in Domicile: Not Filed

Project Number: S30642DBG      Date Approved in Domicile:

Requested Filing Mode: Review & Approval      Domicile Status Comments: Not filed in  
domicile state of Pennsylvania as this is  
deregulated.

Explanation for Combination/Other:      Market Type: Group

Submission Type: New Submission      Group Market Size: Small

Overall Rate Impact:      Group Market Type: Blanket

Filing Status Changed: 01/28/2009      Explanation for Other Group Market Type:

State Status Changed: 01/28/2009

Deemer Date:      Created By: Penny Berry

Submitted By: Wanda Floyd

Corresponding Filing Tracking Number:

Filing Description:

January 23, 2009

Commissioner Julie Benafield Bowman

Department of Insurance

SERFF Tracking Number: AGDE-125989880 State: Arkansas  
Filing Company: National Union Fire Insurance Company of Pittsburgh, PA State Tracking Number: 41907  
Company Tracking Number: S30642DBG  
TOI: H04 Health - Blanket Accident/Sickness Sub-TOI: H04.000 Health - Blanket Accident/Sickness  
Product Name: Speciality Markets  
Project Name/Number: Amendment Endorsement for Organ Donor Transplant/S30642DBG  
1200 W. Third Street  
Little Rock, Arkansas 72201-1904

RE: National Union Fire Insurance Company of Pittsburgh, Pa.  
NAIC # 012-19445, FEIN 25-0687550  
Blanket Accident Insurance Policy C11695DBG et al  
S30642DBG – Amendatory Endorsement For Complications Of Organ Donor Transplant Insurance

Dear Commissioner:

The above-captioned form will be used with our Blanket Accident Insurance Policy C11695DBG, which was previously approved by your Department on August 30, 2001. This form is new and is not intended to replace any existing form previously approved by your Department.

This form is submitted for approval on an out of state issue basis for Organ Donor Registries/Foundations groups.

We are also asking for form and group approval on a discretionary basis under section 23-86-101(7) of the Arkansas Insurance Code as this form will be used by Health Care providers and other discretionary groups.

The referenced program provides limited benefit health insurance. Specifically, the program will provide coverage to eligible individuals who suffer a complication due to Organ donation.

Please do not hesitate to contact our office if you have any questions or require additional information.

Sincerely,

Penny L. Berry  
Regulatory Analyst  
A&H Regulatory Affairs Department  
Phone: 800-225-5244, ext. 2414  
Fax: 302-594-4810  
E-mail: penny.berry@aig.com

**Company and Contact**

SERFF Tracking Number: AGDE-125989880 State: Arkansas  
Filing Company: National Union Fire Insurance Company of State Tracking Number: 41907  
Pittsburgh, PA  
Company Tracking Number: S30642DBG  
TOI: H04 Health - Blanket Accident/Sickness Sub-TOI: H04.000 Health - Blanket Accident/Sickness  
Product Name: Speciality Markets  
Project Name/Number: Admendment Endorsement for Organ Donor Transplant/S30642DBG

### Filing Contact Information

Penny Berry, Product Analyst penny.berry@chartisinsurance.com  
503 Carr Road 888-396-5369 [Phone] 31721 [Ext]  
3rd Floor 302-830-4466 [FAX]  
Wilmington, DE 19809

### Filing Company Information

National Union Fire Insurance Company of CoCode: 19445 State of Domicile: Pennsylvania  
Pittsburgh, PA  
70 Pine Street Group Code: 12 Company Type:  
New York, NY 10270 Group Name: AIG State ID Number:  
(212) 770-7000 ext. [Phone] FEIN Number: 25-0687550  
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### Filing Fees

Fee Required? Yes  
Fee Amount: \$20.00  
Retaliatory? No  
Fee Explanation: 1 endorsement x \$20.00 = \$20.00  
Per Company: No

COMPANY	AMOUNT	DATE PROCESSED	TRANSACTION #
National Union Fire Insurance Company of Pittsburgh, PA	\$20.00	01/23/2009	25222433

SERFF Tracking Number: AGDE-125989880 State: Arkansas  
Filing Company: National Union Fire Insurance Company of Pittsburgh, PA State Tracking Number: 41907  
Company Tracking Number: S30642DBG  
TOI: H04 Health - Blanket Accident/Sickness Sub-TOI: H04.000 Health - Blanket Accident/Sickness  
Product Name: Speciality Markets  
Project Name/Number: Admendment Endorsement for Organ Donor Transplant/S30642DBG

## Correspondence Summary

### Dispositions

Status	Created By	Created On	Date Submitted
Approved-Closed	Rosalind Minor	01/28/2009	01/28/2009

<i>SERFF Tracking Number:</i>	<i>AGDE-125989880</i>	<i>State:</i>	<i>Arkansas</i>
<i>Filing Company:</i>	<i>National Union Fire Insurance Company of Pittsburgh, PA</i>	<i>State Tracking Number:</i>	<i>41907</i>
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<i>TOI:</i>	<i>H04 Health - Blanket Accident/Sickness</i>	<i>Sub-TOI:</i>	<i>H04.000 Health - Blanket Accident/Sickness</i>
<i>Product Name:</i>	<i>Speciality Markets</i>		
<i>Project Name/Number:</i>	<i>Admendment Endorsement for Organ Donor Transplant/S30642DBG</i>		

## Disposition

Disposition Date: 01/28/2009

Implementation Date:

Status: Approved-Closed

Comment:

Rate data does NOT apply to filing.

SERFF Tracking Number: AGDE-125989880 State: Arkansas

Filing Company: National Union Fire Insurance Company of Pittsburgh, PA State Tracking Number: 41907

Company Tracking Number: S30642DBG

TOI: H04 Health - Blanket Accident/Sickness Sub-TOI: H04.000 Health - Blanket Accident/Sickness

Product Name: Speciality Markets

Project Name/Number: Admendment Endorsement for Organ Donor Transplant/S30642DBG

Schedule	Schedule Item	Schedule Item Status	Public Access
Supporting Document	Flesch Certification	Approved-Closed	Yes
Supporting Document	Application	Approved-Closed	Yes
Supporting Document	Transmittal	Approved-Closed	Yes
Form	Amendatory Endorsement for Complications of Organ Donor Transplant Insurance	Approved-Closed	Yes

SERFF Tracking Number: AGDE-125989880 State: Arkansas

Filing Company: National Union Fire Insurance Company of Pittsburgh, PA State Tracking Number: 41907

Company Tracking Number: S30642DBG

TOI: H04 Health - Blanket Accident/Sickness Sub-TOI: H04.000 Health - Blanket Accident/Sickness

Product Name: Speciality Markets

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## Form Schedule

Lead Form Number: S30642DBG

Schedule Item	Form Number	Form Type Form Name	Action	Action Specific Data	Readability	Attachment
Approved-Closed 01/28/2009	S30642DBG	Policy/Cont Amendatory ract/Fratern Endorsement for al Complications of Certificate: Organ Donor Amendmen Transplant Insurance t, Insert Page, Endorseme nt or Rider	Initial		51.500	S30642DBG Organ Donor Rider.pdf



## AIG Domestic Accident & Health Division

A Division of the AIG Companies®

### NATIONAL UNION FIRE INSURANCE COMPANY OF PITTSBURGH, PA.

Executive Offices: 70 Pine Street, New York, NY 10270

(212) 770-7000

(a capital stock company, herein referred to as the Company)

Policyholder: \_\_\_\_\_

Policy Number: \_\_\_\_\_

#### AMENDATORY ENDORSEMENT FOR COMPLICATIONS OF ORGAN DONOR TRANSPLANT INSURANCE

This Endorsement is attached to and made part of the Policy[ as of the Policy Effective Date shown in the Policy's Master Application.][ effective [Month Day, Year]. It applies only with respect to Procedures that occur on or after that date.]. It is subject to all of the provisions, limitations and exclusions of the Policy except as they are specifically modified by this Endorsement.

The following definition is added to the Definitions provision of the Policy:

Procedure –means [an organ donation performed at an accredited facility] [a bone marrow or blood cell donation at a facility that is affiliated with a domestic or foreign member of the National Marrow Donor Program] by a licensed surgeon specializing in the harvesting of the [applicable organ/bone marrow or blood cell donation].

The Accidental Death Benefit and the Accidental Dismemberment Benefit Section on form C11695DBG are removed and replaced with:

**[Accidental Death Benefit.** If Injury to the Insured results in death[ within [90,120,180,365] days of the date of the Procedure that caused the Injury]<sup>5</sup>, the Company will pay 100% of the Maximum Amount.]<sup>9</sup>

**[Accidental Dismemberment Benefit.** If Injury to the Insured due to a Procedure results [ , within [90,120,180,365] days of the Insured's admission into the Hospital for the Procedure that caused the Injury,]<sup>5</sup> in any one of the Losses specified below, the Company will pay the percentage of the Maximum Amount shown below for that Loss:]

For Loss of	Percentage of Maximum Amount
Both Hands or Both Feet.....	100%
Sight of Both Eyes.....	100%
One Hand and One Foot.....	100%
One Hand and the Sight of One Eye.....	100%
One Foot and the Sight of One Eye .....	100%
[Speech and Hearing in Both Ears .....	100%] <sup>6</sup>
One Hand or One Foot.....	50%
The Sight of One Eye.....	50%
[Speech or Hearing in Both Ears .....	50%] <sup>6</sup>
[Hearing in One Ear .....	25%] <sup>7</sup>
[Thumb and Index Finger of Same Hand.....	25%] <sup>8</sup>



“Loss” of a hand or foot means complete severance through or above the wrist or ankle joint. “Loss” of sight of an eye means total and irrecoverable loss of the entire sight in that eye. “Loss” of hearing in an ear means total and irrecoverable loss of the entire ability to hear in that ear. “Loss” of speech means total and irrecoverable loss of the entire ability to speak.<sup>6</sup> “Loss” of thumb and index finger means complete severance through or above the metacarpophalangeal joint of both digits.<sup>8</sup>

If more than one Loss is sustained by an Insured as a result of the same accident, only one amount, the largest, will be paid.<sup>9</sup>

[Exclusion 2 of the Policy, C11695DBG, is changed to read:

2. sickness, disease or infections that are not related to the Covered Activity described in the Master Application.]

[The following Accident Medical Expense Benefit is added:

### **ACCIDENT MEDICAL EXPENSE BENEFIT**

**Accident Medical Expense Benefit.** If an Insured suffers an Injury as a result of a Procedure that, within [30, 60, 90, 180, 365] days of the date of the Insured's admission into the Hospital for that Procedure, requires him or her to be treated by a Physician, the Company will pay the Usual and Customary Charges incurred for Medically Necessary Covered Accident Medical Services received due to that Injury, up to the Maximum Amount per Insured for all Injuries arising from the same Procedure. This benefit is payable only for such charges incurred [after the Deductible has been met and]<sup>1</sup> within [26, 52, 104, 260] weeks after the date of the Procedure that caused the Injury.]

**Covered Accident Medical Service(s)** - as used in this Benefit, means any of the following services:

1. Hospital semi-private room and board (or room and board in an intensive care unit); Hospital ancillary services (including, but not limited to, use of the operating room or emergency room); or use of an Ambulatory Medical Center;
2. services of a Physician or a registered nurse (R.N.);
3. ambulance service to or from a Hospital;
4. laboratory tests;
5. radiological procedures;
6. anesthetics and the administration of anesthetics;
7. blood, blood products and artificial blood products, and the transfusion thereof;
8. physical therapy and occupational therapy;
9. rental of Durable Medical Equipment;
10. artificial limbs, artificial eyes or other prosthetic appliances; or
11. medicines or drugs administered by a Physician or that can be obtained only with a Physician's written prescription.

**Ambulatory Medical Center** - as used in this Benefit, means a licensed facility providing ambulatory surgical or medical treatment, other than a Hospital, clinic or Physician's office.

**[Deductible** - as used in this Benefit, means the amount of Usual and Customary Charges for Medically Necessary Covered Accident Medical Services that must be incurred by the Insured due to Injuries resulting from a Procedure before Accident Medical Expense benefits becomes payable. The amount of the Deductible is the Deductible Amount shown in the Benefit Schedule. Accident Medical Expense benefits are not payable for charges applied to the Deductible.]<sup>1</sup>

**Durable Medical Equipment** - as used in this Benefit, refers to equipment of a type that is designed primarily for use, and used primarily, by people who are injured (for example, a wheelchair or a hospital bed). It does not include items commonly used by people who are not injured, even if the items can be used in the treatment of injury or can be used for rehabilitation or improvement of health (for example, a stationary bicycle or a spa).

**Hospital** - as used in this Benefit, means a facility that: (1) is operated according to law for the care and treatment of injured people; (2) has organized facilities for diagnosis and surgery on its premises or in facilities available to it on a prearranged basis; (3) has 24 hour nursing service by registered nurses (R.N.'s); and (4) is supervised by one or more Physicians. A Hospital does not include: (1) a nursing, convalescent or geriatric unit of a hospital when a patient is confined mainly to receive nursing care; (2) a facility that is, other than incidentally, a rest home, nursing home, convalescent home or home for the aged; nor does it include any ward, room, wing, or other section of the hospital that is used for such purposes; or (3) any military or veterans hospital or soldiers home or any hospital contracted for or operated by any national government or government agency for the treatment of members or ex-members of the armed forces.

**Medically Necessary** - as used in this Benefit, means that a Covered Accident Medical Service is: (1) is essential for diagnosis, treatment or care of the Injury for which it is prescribed or performed; (2) meets generally accepted standards of medical practice; and (3) is ordered by a Physician and performed under his or her care, supervision or order.

**Usual and Customary Charge(s)** - as used in this Benefit, means a charge that: (1) is made for a Covered Accident Medical Service; (2) does not exceed the usual level of charges for similar treatment, services or supplies in the locality where the expense is incurred (for a Hospital room and board charge, other than for a Medically Necessary stay in an intensive care unit, does not exceed the Hospital's most common charge for semi-private room and board); and (3) does not include charges that would not have been made if no insurance existed.

**Exclusions.** In addition to the Exclusions in the Exclusions section of the Policy, Accident Medical Expense benefits are not payable for, and Usual and Customary Charges for Covered Accident Medical Services do not include, any expense for or resulting from any of the following:

1. repair or replacement of existing artificial limbs, artificial eyes or other prosthetic appliances or rental of existing Durable Medical Equipment unless for the purpose of modifying the item because Injury has caused further impairment in the underlying bodily condition.
2. new, or repair or replacement of, dentures, bridges, dental implants, dental bands or braces or other dental appliances, crowns, caps, inlays or onlays, fillings or any other treatment of the teeth or gums, except for repair or replacement of sound natural teeth damaged or lost as a result of Injury up to the Dental Maximum shown in the Benefit Schedule.
3. new eye glasses or contact lenses or eye examinations related to the correction of vision or related to the fitting of glasses or contact lenses, unless Injury has caused impairment of sight; or repair or replacement of existing eyeglasses or contact lenses unless for the purpose of modifying the item because Injury has caused further impairment of sight.
4. new hearing aids or hearing examinations unless Injury has caused impairment of hearing; or repair or replacement of existing hearing aids unless for the purpose of modifying the item because Injury has caused further impairment of hearing.
5. rental of Durable Medical Equipment where the total rental expense exceeds the usual purchase expense for similar equipment in the locality where the expense is incurred (but if, in the Company's sole judgment, Accident Medical Expense benefits for rental of Durable Medical Equipment are expected to exceed the usual purchase expense for similar equipment in the locality where the expense is incurred, the Company may, but is not required to, choose to consider such purchase expense as a Usual and Customary Covered Accident Medical Expense in lieu of such rental expense).

6. personal comfort or convenience items, such as but not limited to Hospital telephone charges, television rental, or guest meals.
7. an Emergency Evacuation for which any benefits are payable under the Policy's Emergency Evacuation Benefit.<sup>3</sup>
8. any condition for which the Insured is entitled to benefits under any Workers' Compensation Act or similar law.<sup>4</sup>

[The following Permanent Total Disability Benefit is added:

#### **PERMANENT TOTAL DISABILITY BENEFIT**

**Permanent Total Disability Benefit (Monthly Benefit)** [ (Not Applicable to Insureds Age [70,75] or Older on the Date of the Procedure)]<sup>1</sup>. If Injury due to a Procedure renders an Insured Permanently Totally Disabled within [90,120,180,365] days of the Insured's admission into the Hospital for that Procedure, and if the permanent Total Disability due to that Injury continues for a period of 12 consecutive months, the Company will pay a monthly benefit equal to the Monthly Rate for the Permanent Total Disability Benefit shown in the Benefit Schedule, starting with the 13th consecutive month of Permanent Total Disability. The benefit is payable monthly as long as the Insured remains continuously Permanently Totally Disabled due to that Injury, but ceases on the earliest of: (1) the date the Insured ceases to be Permanently Totally Disabled due to that Injury; (2) the date the Insured dies; or (3) the date the total amount of monthly Permanent Total Disability benefits paid for all Injuries caused by the same Procedure equals the Maximum Amount. The Company will pay benefits calculated at a rate of 1/30th of the monthly benefit for each day for which the Company is liable when the Insured is Permanently Totally Disabled for less than a full month. Only one benefit is provided for any one month of Permanent Total Disability, regardless of the number of Injuries causing the Permanent Total Disability.

[If the Insured returns to any occupation for which he or she is qualified by reason of education, experience or training on a full or part-time basis, he or she may return to Permanent Total Disability status if: (1) the Insured has not been back to work for longer than 30 days; and (2) the Insured is again Permanently Totally Disabled due to the same Injury which caused the original Permanent Total Disability.]<sup>2</sup> However, with respect to an Insured for whom the occupational definition of Permanently Totally Disabled/Permanent Total Disability is not appropriate,<sup>3</sup> [If the Insured engages in any of the usual activities of a person of like age and sex in comparable health, he or she may return to Permanent Total Disability status if: (1) the Insured has not been engaging in such activities for longer than 30 days; and (2) the Insured is again Permanently Totally Disabled due to the same Injury which caused the original Permanent Total Disability.]<sup>4</sup>

Periods of Permanent Total Disability separated by less than 30 consecutive days will be considered one period of Permanent Total Disability unless due to separate and unrelated causes.

The Company reserves the right, at the end of the first 12 consecutive months of Permanent Total Disability (and as often as it may reasonably require thereafter) to determine, on the basis of all the facts and circumstances, that the Insured is Permanently Totally Disabled, including, but not limited to, requiring an independent medical examination provided at the expense of the Company.

**Permanently Totally Disabled/Permanent Total Disability** - as used in this Benefit, means that the Insured is permanently unable to [perform the material and substantial duties of any occupation for which he or she is qualified by reason of education, experience or training.]<sup>2</sup> However, with respect to an Insured for whom an occupational definition of Permanently Totally Disabled/Permanent Total Disability is not appropriate, Permanently Totally Disabled/Permanent Total Disability means, as used in this Benefit, that the Insured is permanently unable to<sup>3</sup> [engage in any of the usual activities of a person of like age and sex whose health is comparable to that of the Insured immediately prior to the Procedure.]

[The following Weekly Accident Indemnity Benefit is added:

### WEEKLY ACCIDENT INDEMNITY BENEFIT

**Weekly Accident Indemnity Benefit.** If, as a result of an Injury due to a Procedure, the Insured is rendered Totally Disabled within [30, 60, 90, 180, 365] days of the date of the Procedure, the Company will pay a benefit after [1,3,7,14,30,60,90,180] day(s) of Total Disability due to that Injury in any one Period of Disability[, retroactive to the first day of Total Disability in that Period of Disability]<sup>1</sup>. [ No benefit is provided for the first [3,7,14,30,60,90,180]<sup>2</sup> day(s) of Total Disability in that Period of Disability.]<sup>3</sup> The amount of the benefit per week is the lesser of: (1) the Weekly Maximum Amount shown for the Weekly Accident Indemnity Benefit in the Benefit Schedule; or (2) [50, 66 2/3,75]% of Weekly Earnings. It is payable weekly so long as the Insured remains Totally Disabled as a result of an injury due to the Procedure in that Period of Disability, up to the Maximum Number of Weeks shown for the Weekly Accident Indemnity Benefit in the Benefit Schedule in all Periods of Disability resulting from all Injuries caused by the same Procedure. The Company will pay benefits calculated at a rate of 1/7th of the weekly benefit for each day of Total Disability for which the Company is liable when the Insured is Totally Disabled for less than a full week. Only one benefit is provided for any one day of Total Disability, regardless of the number of Injuries causing the Total Disability. No benefits are payable under this Benefit if the Insured had no earnings at the time of the Procedure causing the Injury from an occupation, job or work being performed at that time.

If the Insured returns to perform the material and substantial duties of his or her occupation for any employer on a full or part-time basis, he or she may return to Total Disability status if: (1) the Insured has not been back to work for longer than 30 days; and (2) the Insured is again Totally Disabled due to the same Injury which caused the original Total Disability.

Periods of Total Disability separated by less than 30 consecutive days will be considered one period of disability unless due to separate and unrelated causes.

The Company reserves the right (as often as it may reasonably require) to determine, on the basis of all the facts and circumstances, that the Insured is Totally Disabled, including, but not limited to, requiring an independent medical examination provided at the expense of the Company

**[Coordination with Other Income Benefits.** If the Insured is entitled to Other Income Benefits for any week for which a Weekly Accident Indemnity benefit is payable under this Benefit, the amount of the Weekly Accident Indemnity benefit for that week will be reduced, if necessary, so that the sum of the Weekly Accident Indemnity benefit plus all Other Income Benefits for that week does not exceed [75,100]% of the Insured's Weekly Earnings. If the sum of all Other Income Benefits equals or exceeds [75,100]% of the Insured's Weekly Earnings, no Weekly Accident Indemnity benefit is payable for that week. If any Other Income Benefits are payable on a basis other than weekly, the Company will calculate the equivalent weekly payment and reduce each Weekly Accident Indemnity benefit accordingly.

**Right to Receive and Release Needed Information.** Certain facts are needed to administer the Coordination with Other Income Benefits provision. The Company has the right to decide which facts it needs. It may get needed facts from or give them to any other organization or person. The Company need not tell, or get the consent of, any person to do this. Each person claiming benefits under this Benefit must give the Company any facts it needs to pay the claim.

**Facility of Payment.** A payment made under some Other Disability Plan may include an amount which should have been paid under this Benefit. If it does, the Company may pay that amount to the organization which made that payment. That amount will then be treated as though it were a benefit paid under this Policy. The Company will not have to pay that amount again.

**Right of Recovery.** If the amount of the payments made by the Company is more than it should have paid under the Coordination with Other Income Benefits provision, it may recover the excess from one or more of: (1) the persons it has paid or for whom it has paid; (2) insurance companies; or (3) other organizations.]<sup>4</sup>

**Occupation** - as used in this Benefit, means the occupation, job or work the Insured performed at the time of the Procedure causing the Injury for which benefits are claimed under this Benefit.

**Other Disability Plans** - as used in this Benefit, means: (1) any salary continuation or disability plan provided through the Insured's employer; (2) any group or blanket disability plan (other than this Policy) or like plan for persons in a group; (3) any Worker's Compensation Act or similar law; or (4) the United States Social Security Act or Railroad Retirement Act or any similar plan or act.

**Other Income Benefits** - as used in this Benefit, means any amounts that would be provided because of the Insured's inability to work due to the Injury for which benefits are claimed under this Benefit (or due to a related condition) under Other Disability Plans, in the absence of provisions with a purpose similar to that of the Coordination with Other Income Benefits provision, whether or not claim is made. However, if any Other Disability Plan has a provision to reduce its payments because of Weekly Accident Indemnity Benefits under the Policy, and if the Policy has covered the Insured longer than that Other Disability Plan has, that Other Disability Plan's benefits will not be considered Other Income Benefits.<sup>4</sup>

**Period of Disability** - as used in this Benefit, means a period of consecutive days of continuous Total Disability.

**Totally Disabled/Total Disability** - as used in this Benefit, means that the Insured is unable to perform the material and substantial duties of his or her Occupation for any employer.

**Weekly Earnings** - as used in this Benefit, means the Insured's base weekly earnings in his or her Occupation at the time of the Procedure causing the Injury for which benefits are claimed under this Benefit, but not including overtime, bonuses, tips, commissions, and special compensation.<sup>5</sup>

The President and Secretary of National Union Fire Insurance Company of Pittsburgh, Pa. witness this Endorsement:



President



Secretary

<i>SERFF Tracking Number:</i>	<i>AGDE-125989880</i>	<i>State:</i>	<i>Arkansas</i>
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## Supporting Document Schedules

	<b>Item Status:</b>	<b>Status</b>
		<b>Date:</b>
<b>Satisfied - Item:</b> Flesch Certification	Approved-Closed	01/28/2009
<b>Comments:</b>		
<b>Attachment:</b>		
S30642DBG AR Readability.pdf		

	<b>Item Status:</b>	<b>Status</b>
		<b>Date:</b>
<b>Bypassed - Item:</b> Application	Approved-Closed	01/28/2009
<b>Bypass Reason:</b> Not a policy filing therefore not applicable		
<b>Comments:</b>		

	<b>Item Status:</b>	<b>Status</b>
		<b>Date:</b>
<b>Satisfied - Item:</b> Transmittal	Approved-Closed	01/28/2009
<b>Comments:</b>		
<b>Attachment:</b>		
S30642DBG AR NAIC Transmittal.pdf		

STATE OF ARKANSAS

CERTIFICATION

This is to certify that the attached form number(s) S30642DBG achieved a Flesch Reading Ease score of 51.5 and complies with the requirements of Ark. Stat. Ann. § 23-80-201 through § 23-80-208, cited as the Life and Accident and Health Insurance Policy Language Simplification Act.

A handwritten signature in black ink, appearing to be 'C. A. H.', written over a horizontal line.

Signature \_\_\_\_\_  
Title: Assistant Vice President

**Life, Accident & Health, Annuity, Credit Transmittal Document**

<b>1.</b>	<b>Prepared for the State of</b>	Arkansas					
<b>2.</b>	<b>Department Use Only</b>						
	<b>State Tracking ID</b>						
<b>3.</b>	<b>Insurer Name &amp; Address</b>	<b>Domicile</b>	<b>Insurer License Type</b>	<b>NAIC Group #</b>	<b>NAIC #</b>	<b>FEIN #</b>	<b>State #</b>
	National Union Fire Ins. Co. of Pittsburgh PA 600 King Street - PDV1 Wilmington, DE 19801	Pennsylvania		012	19445	25-0687550	
<b>4.</b>	<b>Contact Name &amp; Address</b>	<b>Telephone #</b>	<b>Fax #</b>		<b>E-mail Address</b>		
	Penny L. Berry 600 King Street - PDV1 Wilmington, DE 19801	302-594-2414	302-594-4810		penny.berry@aig.com		
<b>5.</b>	<b>Requested Filing Mode</b>	<input checked="" type="checkbox"/> Review & Approval <input type="checkbox"/> File & Use <input type="checkbox"/> Informational <input type="checkbox"/> Combination (please explain): _____ <input type="checkbox"/> Other (please explain): _____					
<b>6.</b>	<b>Company Tracking Number</b>	S30642DBG					
<b>7.</b>	<input checked="" type="checkbox"/> <b>New Submission</b> <input type="checkbox"/> <b>Resubmission</b>		Previous file # _____				
<b>8.</b>	<b>Market</b>	<input type="checkbox"/> Individual <input type="checkbox"/> Franchise <input type="checkbox"/> Small <input type="checkbox"/> Large <input type="checkbox"/> Small and Large <input type="checkbox"/> Employer <input type="checkbox"/> Association <input checked="" type="checkbox"/> Blanket <input type="checkbox"/> Discretionary <input type="checkbox"/> Trust <input type="checkbox"/> Other: _____					
<b>9.</b>	<b>Type of Insurance</b>	H04 Health-Blanket AS					
<b>10.</b>	<b>Product Coding Matrix Filing Code</b>	H04 Health-Blanket AS					
<b>11.</b>	<b>Submitted Documents</b>	<input checked="" type="checkbox"/> <b>Forms</b> <div style="display: flex; justify-content: space-between;"> <div> <input type="checkbox"/> Policy  <input type="checkbox"/> Application/Enrollment  <input type="checkbox"/> Schedule of Benefits         </div> <div> <input type="checkbox"/> Outline of Coverage  <input checked="" type="checkbox"/> Rider/Endorsement  <input type="checkbox"/> Other: _____         </div> <div> <input type="checkbox"/> Certificate  <input type="checkbox"/> Advertising         </div> </div> <input type="checkbox"/> <b>Rates</b> <input type="checkbox"/> New Rate <input type="checkbox"/> Revised Rate  <input type="checkbox"/> <b>FILING OTHER THAN FORM OR RATE:</b> Please explain: _____  <b>SUPPORTING DOCUMENTATION</b> <div style="display: flex; justify-content: space-between;"> <div> <input type="checkbox"/> Articles of Incorporation  <input type="checkbox"/> Association Bylaws  <input type="checkbox"/> Statement of Variability  <input type="checkbox"/> Actuarial Memorandum         </div> <div> <input type="checkbox"/> Third Party Authorization  <input type="checkbox"/> Trust Agreements  <input type="checkbox"/> Certifications         </div> </div>					



		<input type="checkbox"/> Other _____
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12.	<b>Filing Submission Date</b>	1/23/2009	
13.	<b>Filing Fee (If required)</b>	Amount <u>20.00</u> Retaliatory <input type="checkbox"/> Yes <input type="checkbox"/> No	Check Date <u>EFT</u> Check Number <u>EFT</u>
14.	<b>Date of Domiciliary Approval</b>	Not Filed	

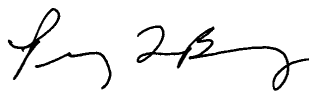
15.	<b>Filing Description:</b>
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This form is new and is not intended to replace any form previously approved by your department. When approved, this form will be utilized with our Blanket Accident Insurance Policy, Form C11695DBG-AR which was approved by your department on 08/30/2001.

**16. Certification (If required)**

**I HEREBY CERTIFY** that I have reviewed the applicable filing requirements for this filing, and the filing complies with all applicable statutory and regulatory provisions for the state of Arkansas.

Print Name Penny L. Berry Title Regulatory Analyst

Signature 

Date: 01/23/2009

<b>17.</b>	<b>Form Filing Attachment</b>	
<b>This filing transmittal is part of company tracking number</b>		S30642DBG
<b>This filing corresponds to rate filing company tracking number</b>		

	<b>Document Name</b>	<b>Form Number</b>		<b>Replaced Form Number</b>
	<b>Description</b>			<b>Previous State Filing Number</b>
01	Amendatory Endorsement for Complications of Organ Donor Transplant Endorsment	S30642DBG	<input checked="" type="checkbox"/> <b>Initial</b> <input type="checkbox"/> <b>Revised</b> <input type="checkbox"/> <b>Other</b> _____	
02			<input type="checkbox"/> <b>Initial</b> <input type="checkbox"/> <b>Revised</b> <input type="checkbox"/> <b>Other</b> _____	
03			<input type="checkbox"/> <b>Initial</b> <input type="checkbox"/> <b>Revised</b> <input type="checkbox"/> <b>Other</b> _____	
04			<input type="checkbox"/> <b>Initial</b> <input type="checkbox"/> <b>Revised</b> <input type="checkbox"/> <b>Other</b> _____	
05			<input type="checkbox"/> <b>Initial</b> <input type="checkbox"/> <b>Revised</b> <input type="checkbox"/> <b>Other</b> _____	
06			<input type="checkbox"/> <b>Initial</b> <input type="checkbox"/> <b>Revised</b> <input type="checkbox"/> <b>Other</b> _____	
07			<input type="checkbox"/> <b>Initial</b> <input type="checkbox"/> <b>Revised</b> <input type="checkbox"/> <b>Other</b> _____	
08			<input type="checkbox"/> <b>Initial</b> <input type="checkbox"/> <b>Revised</b> <input type="checkbox"/> <b>Other</b> _____	
09			<input type="checkbox"/> <b>Initial</b> <input type="checkbox"/> <b>Revised</b> <input type="checkbox"/> <b>Other</b> _____	
10			<input type="checkbox"/> <b>Initial</b> <input type="checkbox"/> <b>Revised</b> <input type="checkbox"/> <b>Other</b> _____	

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<b>18.</b>	<b>Rate Filing Attachment</b>			
<b>This filing transmittal is part of company tracking number</b>				
<b>This filing corresponds to form filing company tracking number</b>				
<b>Overall percentage rate indication (when applicable)</b>				
<b>Overall percentage rate impact for this filing</b>		<b>%</b>		
	<b>Document Name</b>	<b>Affected Form Numbers</b>		<b>Previous State Filing Number</b>
	<b>Description</b>			
01			<input type="checkbox"/> New <input type="checkbox"/> Revised Request + ____% - ____% <input type="checkbox"/> Other _____	
02			<input type="checkbox"/> New <input type="checkbox"/> Revised Request + ____% - ____% <input type="checkbox"/> Other _____	
03			<input type="checkbox"/> New <input type="checkbox"/> Revised Request + ____% - ____% <input type="checkbox"/> Other _____	
04			<input type="checkbox"/> New <input type="checkbox"/> Revised Request + ____% - ____% <input type="checkbox"/> Other _____	
05			<input type="checkbox"/> New <input type="checkbox"/> Revised Request + ____% - ____% <input type="checkbox"/> Other _____	
06			<input type="checkbox"/> New <input type="checkbox"/> Revised Request + ____% - ____% <input type="checkbox"/> Other _____	
07			<input type="checkbox"/> New <input type="checkbox"/> Revised Request + ____% - ____% <input type="checkbox"/> Other _____	
08			<input type="checkbox"/> New <input type="checkbox"/> Revised Request + ____% - ____% <input type="checkbox"/> Other _____	
09			<input type="checkbox"/> New <input type="checkbox"/> Revised Request + ____% - ____% <input type="checkbox"/> Other _____	
10			<input type="checkbox"/> New <input type="checkbox"/> Revised Request + ____% - ____% <input type="checkbox"/> Other _____	

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